THIS DECISION HAS BEEN APPEALED. THE FOLLOWING IS THE RELATED SOAH DECISION NUMBER:

SOAH DOCKET NO. 453-05-3201.M5

MDR Tracking Number: M5-04-1958-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 titled Medical Dispute Resolution of a Medical Fee Dispute, and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 3-1-04.

The IRO reviewed subsequent visit (office visits), stimulation (electrical stimulation, unattended), hot/cold packs, myofascial release, ultrasound therapy, activities (therapeutic activities), aquatic therapy, exercises (therapeutic exercises), neuromuscular (neuromuscular re-education), manual therapy, and evaluation (occupational therapy re-evaluation) on 5-1-03 to 10-6-03.

The Medical Review Division has reviewed the IRO decision and determined that the **requestor prevailed** on the issues of medical necessity. Therefore, upon receipt of this Order and in accordance with §133.308(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor $650.00** for the paid IRO fee. For the purposes of determining compliance with the order, the Commission will add 20 days to the date the order was deemed received as outlined on page one of this Order.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division. On 7-27-04, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

Code 99213 billed on date of service 8-11-03, 9-2-03, 9-30-03, 10-3-03, and 10-6-03 was denied as "N – documentation does not support the service billed."

Per Ingenix EncoderPro, code 99213 requires at least two of these three key components: an expanded problem focused history; an expanded problem focused examination; medical decision making of low complexity. The daily notes did not support the code requirements; therefore, no reimbursement recommended for dates of service 8-11-03 through 10-6-03.

The above Findings and Decision is hereby issued this 16th day of November 2004.
Dee Z. Torres
Medical Dispute Resolution Officer
Medical Review Division

ORDER

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the Respondent to pay the unpaid medical fees outlined above as follows:

- In accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) for dates of service through July 31, 2003;

- In accordance with Medicare program reimbursement methodologies for dates of service on or after August 1, 2003 per Commission Rule 134.202 (c);

- plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this Order.

This Order is applicable to dates of service 5-1-03 through 10-6-03 as outlined above in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Order is hereby issued this 16th day of November 2004.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION

July 21, 2004

Re: IRO Case # M5-04-1958

Texas Worker's Compensation Commission:

___ has been certified as an independent review organization (IRO) and has been authorized to perform independent reviews of medical necessity for the Texas Worker's Compensation

Commission (TWCC). Texas HB. 2600, Rule133.308 effective January 1, 2002, allows a claimant or provider who has received an adverse medical necessity determination from a carrier's internal process, to request an independent review by an IRO.

In accordance with the requirement that TWCC assign cases to certified IROs, TWCC assigned this case to ___ for an independent review. ___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. For that purpose, ___ received relevant medical records, any documents obtained from parties in making the adverse determination, and any other documents and/or written information submitted in support of the appeal.

The case was reviewed by a physician who is Board Certified in Orthopedic Surgery, and who has met the requirements for TWCC Approved Doctor List or has been approved as an exception to the Approved Doctor List. He or she has signed a certification statement attesting that no known conflicts of interest exist between him or her and any of the treating physicians or providers, or any of the physicians or providers who reviewed the case for a determination prior to referral to ___ for independent review. In addition, the certification statement further attests that the review was performed without bias for or against the carrier, medical provider, or any other party to this case.

The determination of the ___ reviewer who reviewed this case, based on the medical records provided, is as follows:

Medical Information Reviewed

1. Table of disputed service 12/30/02 – 10/13/03
2. Explanation of benefits
3. Letter from M.D. 11/14/02
4. Operative report 7/17/03
5. Neurosurgical office notes, including x-ray and MRI reports
6. D.C. reports

History

The patient is a 44-year-old male who injured his lower back in ___ while lifting and twisting from a bent position. He developed pain in the abdomen, lower back and right leg. An MRI was ordered and the patient was referred to a neurosurgeon after nerve compression was noted. The patient stopped working because of continued pain. On 7/17/03 the patient underwent a right L5-S1 laminectomy and diskectomy and forminotomy with graft. Post operatively the patient continued to have pain in the lower back, decreased sensation in the L5 and S1 distribution on the right side, and an acute left L5 radiculopathy.

A new MRI was performed and the possibility of further surgery has been discussed.

Requested Service(s)
Subsequent visit, stimulation, hot cold packs, myofascial release, ultrasound therapy, electric stimulation therapy, activities, aquatic therapy, exercises, neuromuscular, manual therapy, evaluation 5/1/03 – 10/6/03

Decision
I disagree with the carrier's decision to deny the requested services.

Rationale
The disputed services were performed in the pre and post-surgical period to deal with the patient's difficulty. The treatments were appropriate, reasonable and necessary and were not excessive. The notes provided adequately document and justify the ongoing treatment during this time.

This medical necessity decision by an Independent Review Organization is deemed to be a Commission decision and order.